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March 15, 2010 Deadline Set for Comment on CMS and ONC Proposed HIT Rules

The Centers for Medicare & Medicare Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) encourage public comment on two recently issued regulations issued which lay a foundation for improving quality, efficiency and safety through meaningful use of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of EHR technology. An interim final regulation issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

The Recovery Act established programs to provide incentive payments to eligible professionals and eligible hospitals participating in Medicare and Medicaid that adopt and make "meaningful use" of certified EHR technology. Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

CMS' proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information.

The proposed rule would phase in more robust criteria for demonstrating meaningful use in three stages. For stage 1, which begins in 2011, CMS proposes 25 objectives and measures for eligible providers and 23 objectives and measures for eligible hospitals that must be met to be deemed a meaningful EHR user. Stages 2 and 3 will be defined in future CMS rulemaking.

The 60-day comment period for both rules will end at 5:00 PM EDT on Monday, March 15, 2010. All comments to be considered for the final rule must be submitted via the normal comment process. CMS' proposed rule, as well as ONC's proposed rule, can be found on the federal government's regulations website. All HIT-related information can be found on the HIT page of the CMS website.

Medicare Now Covers HIV Screenings

CMS has announced its final decision to cover Human Immunodeficiency Virus (HIV) infection screening for Medicare beneficiaries who are at increased risk for the infection, including women who are pregnant and Medicare beneficiaries of any age who voluntarily request the service. The decision is effective immediately.

Under the recently passed Medicare Improvements for Patients and Providers Act of 2008, CMS now has the flexibility of adding to Medicare's list of covered preventive services, if certain requirements are met. Prior to this law, Medicare could only cover additional preventive screening tests when Congress authorized it to do so.

"Today's decision marks an important milestone in the history of the Medicare program," said HHS Secretary Kathleen Sebelius. "Beginning with expanding coverage for HIV screening, we can now work proactively as a program to help keep Medicare beneficiaries healthy and take a more active role in evaluating the evidence for preventive services."

More information about Medicare's new HIV screening benefit is available in CMS' final decision memorandum.

2009 *CMS Statistics* Now Available

The 2009 edition of *CMS Statistics* is now available. *CMS Statistics* is an annual publication prepared as a handy reference document for anyone needing data related to CMS programs. The data are comprehensive, with summary CMS program information. The electronic version of the 2009 *CMS Statistics* is available on the CMS website.

Inside this Issue...

CMS Launches Fifth Annual Satisfaction Survey

CMS wants to hear from you about your satisfaction with the services provided by Medicare fee-for-service (FFS) contractors which process and pay Medicare claims. CMS has launched the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors.

Approximately 30,000 randomly selected providers were notified in January that they have been selected to participate in the survey. CMS urges all health care providers selected to participate in the 2010 survey to take a few minutes to complete and return this important survey. Go to the CMS website to read the CMS press release announcing the launch of the 2010 MCPSS.

HIPAA Version 5010 Resources

The implementation of HIPAA Version 5010 presents substantial changes in the content of the data that providers submit with their claims, as well as the data available to them in response to their electronic inquiries for eligibility or claims status. These new educational materials inform providers of these changes and how they need to plan for their implementation. This information is designed for Medicare fee-for-service providers; however, it may be of interest to all health care providers.

Go to the CMS 5010 website and click on "Educational Resources" to view these new educational products.

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CMS Delays Implementation of Ordering/Referring Providers Edit to 2011

CMS has pushed back implementation of its Expansion of the Current Scope of Editing for Ordering/Referring Providers, as outlined in Change Request (CR) 6417 and CR 6421, from April 5, 2010 until January 3, 2011. CR 6417 describes the application of this initiative for providers who bill Medicare carriers and Part B MACs and CR 6421 applies to durable medical equipment, prosthetic, orthotics and supplies (DMEPOS) suppliers. As of this new date, Medicare will reject claims if the ordering or referring provider does not have an active enrollment record in Medicare's Provider Enrollment Chain and Ownership System (PECOS), or is not of the correct type/specialty to order or refer services to Medicare beneficiaries.

CR 6417 permits Medicare carriers and Part B MACs to check their master provider file for an active enrollment record and for the practitioner's specialty if it is not found in PECOS. DME MACs do not have access to a database other than PECOS to verify active providers and their specialties.

In Phase 1 of this project, which began on October 5, 2009, DMEPOS suppliers and Part B providers who submit electronic claims started receiving a warning message on their Common Electronic Data Interchange reports if the ordering/referring provider is not in PECOS or is in PECOS but is not the correct type/specialty to order or refer services. During Phase 1, the claims hitting these edits will continue to process. However, their claims will reject starting January 3, 2011 if they fail these new edits.

CMS recently posted the Ordering/Referring Report, a list of physician and non-physician practitioners who are eligible to order or refer items or services for Medicare beneficiaries because they have an active enrollment record in PECOS and are of a right specialty or type to order or refer items or services. Individual practitioners are encouraged to check this list to make sure that they are on it. If not, they need to submit an 855I Provider Enrollment form to their local carrier and update their enrollment information to have an active enrollment record. This can be done through the on-line Internet-based PECOS or by mailing a paper application to your local carrier.

Please see MLN Matters articles MM6421 and MM6417 for additional information on this initiative as well as for a complete list of types of practitioners who can order or refer Medicare beneficiaries for items or services.

Updates for the 2010 Physician Quality Reporting Initiative Program

Participation in PQRI offers the participating provider a bonus Incentive Payment of 2 percent of total allowable charges for successful reporting in 2010. There are several reporting mechanisms available to eligible professionals (EPs) for the 2010 reporting period. These include claims based reporting of individual measures and group measures, reporting through a qualified registry, a group practice reporting option, and an option for individual measures reporting only through a qualified electronic health record.

Based upon the types of measures chosen and the method of reporting there are two reporting periods to choose from: January 1, 2010 through December 31, 2010; or July 1, 2010 through December 31, 2010.

For the 2010 reporting period, CMS has chosen 175 individual measures, including 46 registry-only measures, 10 measures for EHR-based reporting, and 30 new measures. The measure specifications for the 2010 individual PQRI measures and 2010 PQRI measures groups for individual EPs are posted on the CMS website.

As required by the Medicare Improvements for Patients and Providers Act of 2008, CMS intends to publicly report the names of EPs and group practices who satisfactorily report who are successful electronic prescribers and who successfully report PQRI in 2010. All PQRI information can be found on the PQRI page of the CMS website.

Billing Reminder: Mandatory Claims Submissions

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries. The requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment. Compliance to mandatory claim filing requirements is monitored by CMS, and violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation, a 10 percent reduction of a physician's/supplier's payment once the physician/supplier is brought back into compliance, and/or Medicare program exclusion. Medicare beneficiaries may not be charged for preparing or filing a Medicare claim.

CMS' requirement for mandatory claims submission can be found in the Medicare Claims Processing Manual, Chapter 1, Section 70.8.8.

CMS allows exceptions to the mandatory filing requirement, which can be found in the Medicare Claims Processing Manual, Chapter 1, Section 70.8.8.8. Keep in mind that providers and suppliers are not required to file a claim for a service that is categorically excluded from coverage (e.g., cosmetic surgery, personal comfort services, etc). However, many Medicare supplemental insurance policies pay for services that Medicare does not allow, and they may require a Medicare denial notice.

CMS Announces 2010 Institution Guidelines for Additional Documentation Limits for RAC Program

CMS has issued the guidelines for the additional documentation limits for fiscal year 2010 in the Recovery Audit Contactor (RAC) program. The limits established are for institutional providers.
These limits will be set by each RAC on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior fiscal year Medicare claims volume.

Limits will be set at 1 percent of all claims submitted for the previous calendar year (2008), divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services.

Two caps will exist in FY 2010. Through March 2010, the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers. However, from April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per Tax Identification Number, across all claims processing contractors) will have a cap of 300 additional documentation requests per campus unit, per 45 days.

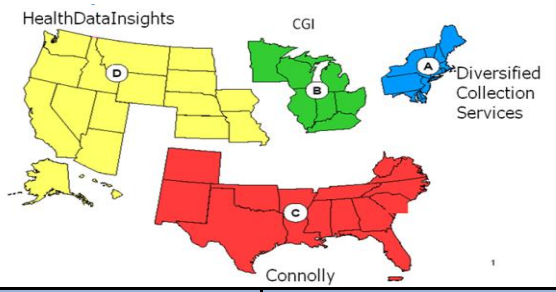
In addition, in FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.

Keep Up-to-Date with RAC Issues

CMS also encourages all providers to keep abreast of the issues that are currently under review. The issues under review at all 4 RAC contractors can be found at the following links:

Jurisdiction A: Diversified Collection Services (DCS)
Jurisdiction B: CGI Federal
Jurisdiction C: Connolly Healthcare
Jurisdiction D: Health Data Insights

RAC Jurisdictions



RAC	Website	e-Mail	Telephone
Region A: DCS Healthcare Services	dcsrac.com	info@dcsrac.com	866-201-0580
Region B: CGI Federal Inc.	racb.cgi.com	racb@cgi.com	877-316-7222
Region C: Connolly Healthcare	connollyhealthcare.com/RAC	RACinfo@connollyhealthcare.com	866-360-2507
Region D: HealthDataInsights	racinfo.healthdatainsights.com	racinfo@emailhdi.com	Part A: 866-590-5598 Part B: 866-376-2319

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Update on Use of Emergency Codes and Modifiers

As part of its response to the 2005 the Hurricane Katrina emergency, CMS developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. Use of these indicators was also authorized for claims affected by subsequent emergencies. The discretionary use of these indicators by a provider or supplier was permitted and such use signified not only that the item or service was affected by an emergency or disaster, but also that the provider or supplier had met all of CMS' requirements related to the furnishing of such item or services during the emergency or disaster.

Subsequently, on July 31, 2009, CMS issued Transmittal 1784 (CR 6451) which, among other things, narrowed the scope of permitted uses of these indicators. In particular, it eliminated the discretionary use of both the "DR" condition code and the "CR" modifier by providers and suppliers.

For the H1N1 pandemic emergency, CMS authorized the use of the "DR" condition code and the "CR" modifier only by providers who have been granted a formal waiver under § 1135 of the Social Security Act and then only for services affected by the emergency and while the waiver remains in effect. No other provider or supplier may use either indicator at this time.

Providers and suppliers who have been annotating their claims with one or both indictors should cease doing so (unless they are operating under a formal 1135 waiver). Processing of claims annotated with these indicators that are submitted by providers and suppliers who have not been granted an 1135 waiver, may be delayed.

Please contact your local CMS Regional Office if you have questions or need more information.

CMS Approves Three National Accreditation Organizations for Imaging Services

CMS has designated three national accreditation organizations — the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission — to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging procedures. The accreditation requirement will apply only to the suppliers furnishing the imaging services, and not to the physician's interpretation of the images.

As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), all suppliers of the TC of advanced imaging will have to become accredited by an accreditation organization designated by the Secretary of Health and Human Services by January 1, 2012. The accreditation requirement applies to physicians, non-physician practitioners, and physician and non-physician organizations that are paid for providing the TC of advanced imaging services under the Medicare Physician Fee Schedule.

MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine imaging such as positron emission tomography. The details of the accreditation organization selection process went through notice and comment rulemaking in the calendar year 2010 Physician Fee Schedule rule.

MIPPA specifically excluded from the accreditation requirement certain imaging services, such as x-rays, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

CMS will issue further guidance to suppliers about meeting the accreditation requirements. CMS plans to undertake a provider education outreach program to ensure that all affected suppliers understand the requirements and are able to comply with them prior to the January 1, 2012, accreditation deadline.

For more information, please see the CMS Web site.

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

MLN Celebrates 10th Anniversary

This year marks the 10th anniversary for the Medicare Learning Network (MLN) – the home for official information for Medicare fee-for-service (FFS) providers. MLN has been very busy producing quality educational products designed to meet the needs and learning styles of busy health care professionals, adding continuing education credits to many of our online courses, and developing new and different ways to make our products accessible and available to the FFS provider community.

View the new Marketing Brochure online to learn what the Medicare Learning Network has to offer. Print copies of this brochure will soon be available on our Product Ordering System.

Also, the Medicare Learning Network DVD contains quick and basic information about the Medicare Learning Network and its benefits to providers. National and local provider associations are encouraged to post this product on their websites and/or distribute via electronic newsletters or mailing lists.

Visit the Medicare Learning Network Product Ordering Page and scroll down to the "Educational Tool" topic category to find the DVD and place your order. You can also view the video online.